MEDICAID OBSTETRICAL AND MATERNAL SERVICES PROGRAM (MOMS)
Application for Enrollment as a Specialist

INSTRUCTIONS:
1. Type or print the information in the space provided.
2. Attach required documentation:
   (a) certification by an appropriate specialty board;
   (b) notice of admissibility to final examination from appropriate specialty board; or
   (c) evidence of satisfactory completion of residency or fellowship training (family practitioners);
3. Submit a copy of your current license registration
4. Sign and date the Assurances.
5. Submit completed application, and required documentation to NYS Department of Health, Bureau of Women's Health, MOMS Unit, Corning Tower – 18th Floor, Empire State Plaza, Albany, New York 12237.
6. Application process is approximately 120 days

SECTION A – IDENTIFYING INFORMATION

1. First Name _____ Last Name _____
2. Business Address _____
3. Daytime Telephone Number (_____) _____ Date of Birth _____/_____/_____
4. (a) License # _____ (b) State _____
5. Medical School _____ Year Graduated _____
6. Please complete this question ***if you are*** an enrolled Medicaid provider

   Medicaid ID # _____

SECTION B – PRACTICE INFORMATION

7. If you employ/use the services of one or more nurse practitioners, midwives, and/or physician assistants, please give name(s) and license(s) below:

NAME	LICENSE #	STATE

SECTION C – ACTIVE HOSPITAL PRIVILEGE (Check one)

8. ☐ As a physician or licensed midwife, I have an active admitting privilege at an accredited hospital with maternity services. A current copy of my hospital appointment letter is attached.

   ☐ As a Nurse Practitioner, I have a collaborative agreement with a Medicaid-enrolled physician who is board certified by the American College of Obstetrics and Gynecologists or an active candidate for a period of no more than five years from completion of a postgraduate training program in obstetrics and gynecology or board certified by the American Board of Family Practice and who has active admitting privileges at an accredited hospital with maternity services. I assure that for the purposes of this program, my practice will be limited to provision of prenatal and postpartum care.

   ✓ A copy of this agreement and the physician's hospital letter are attached.

SECTION D – ASSURANCES

1. I recognize that I continue to be bound by the rights, obligations, duties, or interests accrued or conferred as a result of my enrollment in the New York State Medicaid Program.

2. As an obstetrical care physician, midwife, or nurse practitioner, I assure the provision of comprehensive medical care services to Medicaid patients who are pregnant or postpartum, in accordance with the practice guidelines established by the American College of Obstetricians and Gynecologists or the American Academy of Family Practice Physicians or the American College of Nurse Midwives.

3. I assure that I will provide prenatal diagnostic and treatment services including but not limited to the following:
   - (i) an initial comprehensive assessment including history, review of systems, and physician examinations;
   - (ii) standard laboratory tests and procedures;
   - (iii) needed special laboratory tests as indicated by comprehensive assessment and initial or preliminary test findings;
   - (iv) evaluation of risk;
   - (v) discussion with the woman of options for treatment, care and technological support that are expected to be available at the time of labor and delivery together with the advantages and disadvantages of each option;
   - (vi) postpartum counseling, evaluation and referral to professional care and services, as required, to include preconception counseling as appropriate.

4. As an obstetrical care physician, midwife, or nurse practitioner, I agree to provide medical care coordination as a part of my care, such medical care coordination to include at a minimum: the scheduling of elective hospital admissions; where possible, assistance with emergency admissions; management of and/or participation in hospital care and discharge planning; scheduling of referral appointments with written referral as necessary and with request for follow-up report; and the maintenance of a complete medical record to include but not to be limited to notation of referrals and hospitalizations, and copies of test results and reports.

5. As a participating practitioner, I assure that all Medicaid eligible women under my care will have access to non-medical health supportive services such as health education, nutrition assessment and counseling, psychological assessment and counseling, non-medical case management, determining presumptive eligibility for Medicaid, acting as authorized representative for the Medicaid application process, and HIV counseling and testing. I understand that I may apply to provide this service directly or that I will have an agreement with an approved health supportive service provider. I understand that this agreement requires me to refer all women in this category by means of a written referral form and to provide them and the receiving agency(ies) with a referral form supplied by the New York State Department of Health. I understand that the New York State Department of Health has provided me with a list of approved health supportive service providers. If I do not provide these services directly, I agree to sign an agreement with one or more of these providers to accept referrals from me of pregnant Medicaid recipients. I agree to list at No. 14a of this application a health supportive service provider with whom I will sign an agreement. If not in a Health Supportive Services Provider arrangement, but providing services through subcontract with a PCAP, please list name of PCAP at No. 14b.

6. As an obstetrical care physician, licensed midwife, or nurse practitioner, I assure that I will maintain 24-hour telephone coverage which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement cannot be met by a recording referring patients to the emergency room.

7. I assure that I will request, as necessary, from the New York State Department of Health, and display conspicuously on my premises, designated informational materials that serve to inform the public regarding Medicaid eligibility and services for pregnant women and children.

8. I assure that I will notify the New York State Department of Health within thirty (30) days of circumstances resulting in my *ineligibility* to continue this agreement and/or my *inability* to perform the activities and services required under this agreement.

9. I recognize that the State may determine new visit types and rates during the term of this agreement and that the new visit types and rates may supersede those available at the time of this agreement.

10. I assure that I will abide by all reasonable policies, procedures, and instructions provided by the State to implement and execute the Medicaid Obstetrical and Maternal Services program, and will bill Medicaid in accordance with the reimbursement methodology established by the State.

11. I recognize that the New York State Department of Health may cancel my participation in the Medicaid Obstetrical and Maternal Services program at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the Medicaid Obstetrical and Maternal Services program will include but not be limited to my failure to comply with these assurances.

12. I recognize that I may request cancellation of participation in the Medicaid Obstetrical and Maternal Services program when there are extenuating circumstances, giving the New York State Department of Health not less than thirty (30) days of written notice. I assure that such cancellation will include a description of the basis for the termination. I assure that I will assist patients to maintain continuity of care; provide them with information to assist them to transfer their care; and make timely transfer of their records upon request.

13. I accept that, upon my designation by the New York State Department of Health to participate in the Medicaid Obstetrical and Maternal Services program, these ASSURANCES will be effective beginning with the date of this application (Item 17) and may continue in effect thereafter with the consent of both parties and so long as federal financial participation is available. I accept that services rendered prior to October 1, 1992 will not be eligible for reimbursement through the Medicaid Maternal and Obstetrical Services program.

14. a. If applying for MOMS, I agree to refer all pregnant Medicaid recipients or those who may be eligible to an approved MOMS Health Supportive Services Provider. Please list name of HSSP

    _____

    b. If applying for MOMS as a PCAP subcontractor, please list name of PCAP. As a PCAP subcontractor, I understand that I am only eligible to bill Medicaid for deliveries.

    _____

    ☐ There are no health supportive service providers or PCAPs in my area.

    ☐ Please send an application to provide health supportive services.

15. PRINT NAME _____

16. SIGNATURE _____

17. DATE _____